OREGON HEALTH & SCIENCE UNIVERSITY

Doernbecher Children's Hospital

School of Medicine
Division of General Pediatrics

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November 1, 2021

U.S. Senate Committee on Finance
Washington, DC 20510-6200

[*Delivered via email to mentalhealthcare@finance.senate.gov*]

RE: Bipartisan Mental Health Request for Information

Senator Ron Wyden and Members of the Committee on Finance:

Thank you for the opportunity to provide comments in response to your recent Request for Information regarding behavioral health care. As clinicians focused on the care of children and adolescents, we have provided answers, and related recommendations, in response to the five questions under the heading, *Improving Access for Children and Young People*. We welcome further discussion and thank you again for your attention to these critical issues.

1. How should shortages of providers specializing in children's behavioral health care be addressed?

   Despite the fact that across the country, one in five children will experience a mental health condition in any given year, and in Oregon, suicide is the second-leading cause of death among 10- to 24 year-olds, there remains a severe shortage of children's behavioral health providers. It is all too common for child patients to have a different therapist every month and never have the chance to benefit from the critical relationships necessary for effective therapy. There are dozens of families within Doernbecher Children's Hospital who are in need of behavioral health help who simply cannot find it. While the causes of this shortage are complex, it is well understood that lower reimbursement rates for behavioral health services (compared to medical and surgical treatments) are a key factor, compounded by Medicaid's overall lower reimbursement rates. In order to address the provider shortage and to meet Oregon's goals around equity (given that children of color are disproportionately covered on Medicaid), both investments in traditional workforce measures, namely graduate medical education (GME), and increased Medicaid rates will be necessary.

   Recommendations:
   - Increase GME slots to expand training for Child and Adolescent Psychiatry Fellowships as well as Developmental and Behavioral Pediatrics.
   - Maintain public service loan repayment programs.

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- Increase Medicaid rates for clinical services delivered in community mental health programs and provide competitive wages for those who serve the most complex and diverse patient populations, as well as capital maintenance and investment and the cost of training and supervision.
- Require insurers to maintain a continuum of care via capacity payments for intensive service array and eliminate credentialing barriers, especially in low resource communities.
- Establish network adequacy provisions ensuring that mental health coverage includes a sufficient number of accessible providers.
- Create incentives for investments in early interventions and prioritize delivery of prenatal and early childhood providers and training.

2. How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?

   Peer support, community health workers, and non-clinical professionals can serve as connectors, conveners and workforce members to integrate the disparate systems in a more equitable manner, as they are more likely to represent the communities they serve in terms of cultural, racial, ethnic, and linguistic attributes.

   Recommendations:
   - Outreach to underserved communities and individuals is a critical component to reduce access barriers related to racism cultural and language barriers.
   - Medicaid funds should be allowed to be utilized for non-clinical encounters in order to increase wages to people with lived experiences who fulfill these roles.
   - Create pathways to advancement to retain workforce.
   - Create certification training and supervision pathways for these providers.

3. Are there different considerations for care integration for children's health needs compared to adults' health needs?

   The health of a child is not compartmentalized into physical, dental, or mental health. The health care system, however, silos funding streams so they are too complicated to truly connect. In addition, the disparate systems of education (early childhood and K-12), child welfare, housing and nutrition services, create a dynamic where there is little mutual incentive to optimize child health from an interdisciplinary, cross-sector standpoint. Having everyone invested in the well-being of a child would require alignment of systems and funding to focus on child outcomes. Kids are not little adults. Even among kids, the brain of a 1 year old is fundamentally different than a 2 year olds. How kids are cared for, where and by whom, varies massively over time, so the systems and processes necessary to ensure optimal

development and health for kids require engagement of the specific resources and services who serve them.

Recommendations:

- Integrate social determinants of health (SDOH) into care integration practices by funding peer delivered SDOH coordination and support who can work in primary care settings.
- Create fellowships for primary care providers (PCPs) who may be interested in an additional year of training to address behavioral challenges for youth.
- Remove credentialing and payment barriers for integrated health providers billing from the primary care medical home.
- Consider payment strategies to implement health promotion and prevention work in the primary care medical home around parenting, attachment resilience training that is not diagnostically based.

4. How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?

   Everything possible should be done to support kids, parents, and caregivers in the earliest periods (pre-natal and very early childhood) to prevent engagement in the child welfare or justice system. This is about mitigating adverse childhood events (ACES) risk for kids and addressing the trauma of parents and caregivers to build resilience. We need to be working far upstream on this: housing is child health. Food is child health, education and learning are child health. They cannot be separated, and our system does just that.

   Recommendations:

   - Eliminate barriers to maintaining Medicaid authorization for incarcerated youth.
   - Utilize a severity complexity tool that would allow a youth to access Medicaid without entering foster care and make it possible that these same youth (complex) retain Medicaid coverage to age 26.
   - Develop practices in child welfare and juvenile justice that involve adult training in the impact of trauma and how to interact with traumatized youth and training youth to recognize the impact of trauma and how to regulate.
   - Shift from a "you are damaged" framework to one based on finding strengths and creating education.
   - Invest in data-driven practices to prevent engagement in the foster care and juvenile justice systems.

5. What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?

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Like adult patients, children and adolescents benefit tremendously from having access to telehealth options depending on their circumstances and needs. Recently, one of our patients needed help addressing their depression and anxiety. This patient lived 30 minutes away, had no access to transportation, and could not access virtual visits without their parent. The parent worked until late in the evening, and so we had a phone visit, leading to medication prescription. The success of these types of solutions relies on payment parity between virtual services, audio-only services, and in-person services. It also relies on access to technology. The growing digital divide, itself a huge equity issue, must be addressed immediately.

Recommendations:

- Make permanent the pandemic-related authorization of payment for virtual care (including audio-only) given the unequal access to technology.
- Support the Reciprocity to Ensure Access to Treatment (TREAT) Act, which would provide temporary licensing reciprocity for health care professionals for any type of services provided to a patient located in another state during the pandemic, and explore longer term solutions for addressing service deserts across the U.S.
- Require insurers to maintain adequate panels of behavioral health providers in order to ensure access, including utilizing in-network telehealth visits.
- Improve access to technology in the home or expand access to virtual care through use of underutilized buildings in the patient's community.

Thank you again for your consideration and the opportunity to provide comments,

Sincerely,

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